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THE WALLS COME TUMBLING DOWN

TESTIMONY ON COMMUNITY MENTAL HEALTH CENTERS ACT (S.755)

SENATE COMMITTEE ON LABOR AND PUBLIC WELFARE (SEN. HILL, CHAIRMAN)

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by

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Mr. Chairman and Members of the Committee:

In 1945, as a newspaper reporter in Oklahoma, I got my first vivid taste of the way in which society isolated the mentally ill.

The largest mental hospital in Oklahoma was situated in the beautiful university town of Norman, only twenty miles from Oklahoma City. The hospital itself was less than a mile from the superbly appointed campus of the University of Oklahoma, yet for all practical purposes, it could have been a thousand light years away. There was a guard at the gate of the institution and you had to wait until he cleared you with the central office before you were admitted beyond the high walls surrounding the institution. In the many days subsequent to my first visit, I searched futilely for some evidences of contact and liaison between this state institution and the university, the medical school or the outside world.

Eighteen years ago, I tried to sum up the anger and bewilderment I felt in these words:

"It had all the rigidity of a medieval morality play -- you went from the Heaven of a university campus to the Hell of a block of old dungeons holding thousands of sick, screaming patients.

"Walls, walls, walls. They had a reality to me far beyond anything else I saw at that time. I had a fantasy of borrowing a bulldozer and running it from the university campus right smack through the walls of the State Institution. For the walls represented to me one thing -- they were a physical symbol of the fears of the community outside. The people in the intellectual little university town of Norman somehow felt protected because a wall symbolized the end of one kind of life and the beginning of unmentionable misery and madness."

In subsequent years, I visited scores of mental institutions and found only small differences from the basic pattern I had seen in Oklahoma. The "philosophy" underlying legislative provisions for the mentally ill was a very simple one. They were a hopeless segment of our society, untreatable and incurable, and therefore certainly not a medical problem. The level of subsistence was frightfully low -- the food was bad, the clothing was meagre and any thought of individual medical treatment was out of the question.

Because treatment was lacking in these institutions purposely removed from the vision of the average citizen, it was inevitable that the patient load would grow to fantastic proportions. In some states, mental hospitals expanded to a capacity of 10,000 and even 15,000 beds. In the decade from 1945 to 1955 alone, 100,000 additional patients were piled upon the already bursting capacities of these outmoded human warehouses.

In the years following World War II, there were the beginnings of a revolt against a system which confined sick patients in institutions for anywhere from ten to sixty years at a tremendous cost to the taxpayer. Some of us felt very strongly that if we could enlist the support of the citizens and the medical profession, we could bring to an end what I have often referred to as "the Age of Banishment."

Seven years ago, in a talk in Philadelphia, I expressed the conviction that "this age is coming rapidly to a close and I think it is fair to state that we are on the threshhold of a great new era -- the treatment of mental illness in the heart of the community. As we have over the past several decades built a magnificent system of hospital care for the treatment of physical illness within the confines of our community, so shall we in the next several decades do the same for mental illness."

I don't want to leave the impression that the situation was totally hopeless during those years. The establishment by the Congress of the National Institute of Mental Health in 1946 was the first major break away from the old custodial philosophy. The Congress defined the role of the Institute as a stimulatory one -- placing its major emphasis upon research, training and matching clinic grants to aid the states and localities in developing intensive treatment programs as an alternative to the isolation and virtual quarantine of most mental patients.

For example, the Institute's training activities have resulted in the vital addition of more than 10,000 skilled workers to the mental health field over the past 15 years. In the staffing of state institutions and mental health clinics, it is frightening to contemplate what the situation would have been if this program had not existed.

The interest of the Congress in a more fundamental attack upon mental illness was further dramatized in 1955 by the passage of legislation granting partial federal support to the Joint Commission on Mental Illness and Health to enable it to carry out a critical survey of the care of the mentally ill in this country. Thirty-six national organizations, including the American Psychiatric Association, the American

Medical Association and the American Legion, participated in six years of study preceding the submission of the Joint Commission's final report to the Congress in March, 1961.

In calling for a tripling of national expenditures for mental health services by 1970, with the federal, state and local governments sharing in this effort, the Commission report critized the heavy past reliance upon state expenditures in this forthright statement:

> "It was a historic mistake to make the state alone virtually responsible for public care of its mentally ill residents, relieving the local communities of all future concern and until recent times sparing the federal government anything but peripheral involvement in the problem. Their single source of financial support guarantees the isolation of state hospitals and the dumping ground effect we have stressed."

On February 5th, 1963, in the first message ever transmitted to the Congress by a President of the United States on mental illness and mental retardation, President Kennedy called for a revolutionary approach to both problems in these stirring words:

> "Merely pouring federal funds into a continuation of the outmoded type of institutional care which now prevails would make little difference", the President told the Congress. "The time has come for a bold new approach. New medical, scientific and social tools and insights are now available. A series of comprehensive studies initiated by the Congress, the executive branch and interested private groups have been completed and all point in the same direction."

The Presidential message is a powerful attack upon routine confinement of the mentally ill. Noting that 45% of the inmates of state mental institutions have been hospitalized continuously for ten years or more, the President includes in the budget for the coming year $10 million in grants to state hospitals for both pilot projects demonstrating new intensive treatment services and pilot training programs to increase the competence of present hospital ward personnel.

However, the heart of the Presidential message is concentrated upon legislation providing matching federal funds for the construction and operation of comprehensive community mental health centers. As the President noted in his message:

> "We need a new type of health facility, one which will return mental health care to the mainstream of American medicine and at the same time upgrade mental health services. . . Located in the patient's own environment and community, the center would make possible a better understanding of his needs, a more cordial atmosphere for his recovery and a continuum of treatment."

The legislation proposes no rigid guidelines in the establishment of these centers. The planning grants made available by the Congress during the current year, and for a second year in the President's budget submission, encourage a wide degree of state and local initiative. As the Presidential message suggests, in some states the proposed centers might be located in community general hospitals; in other states, existing mental health clinics might be expanded to encompass residential treatment and after-care facilities while, in still others, new centers might be sponsored by local governments or by voluntary, non-profit organizations.

It is important to emphasize that these centers are not to be viewed as temporary first aid stations, applying band-aids to patients eventually ticketed for state institutions. In providing -- as a minimum -- diagnostic services, in-patient residential care, out-patient treatment and day care for patients living at home, they will supply treatment services <u>in depth</u> as an alternative to lengthy institutionalization.

I want to applaud the provision in the legislation before this committee which requires the creation of state advisory councils to work with the designated state agency in developing comprehensive community services. The inclusion on these councils

of representatives of state and local mental health associations, of medical societies, and of other non-governmental lay and professional organizations, will go far toward guaranteeing grass roots support and identification, particularly in the crucial years following the pilot phase of building and operating these centers.

The states are ready for this kind of planning. Since 1949, the National Governors' Conference has directed continuous attention to the problem of mental illness. In November, 1961, at a special National Governors' Conference convened to discuss the Joint Commission report, the Governors unanimously adopted a declaration of policy which stated unequivocally that "75% of the acutely mentally ill who receive intensive treatment in community facilities will not require costly institutionalization. . . Whenever possible, the patient should be treated in the community through mental health clinics, emergency and short-term psychiatric services in general hospitals, day and night hospitals, halfway houses and other rehabilitation facilities."

At their 54th annual conference in 1962, the Governors went a step further by resolving "that each state develop a comprehensive master plan for coping with mental disability and promoting mental health that will mobilize state and local, private and voluntary resources."

Although many of these developments are still in their very early stages, it is heartening to note that 23 states are currently involved in planning new kinds of mental health facilities.

Just outside of Portland, Oregon, the state has constructed a small, intensive treatment hospital handling some 300 patients. The Dammasch Hospital, which boasts a ratio of one doctor to every thirty patients and which takes all patients from two

counties comprising one-third of the population of Oregon, has been in existence a little over two years. Although the per diem is running about $14.00 a day, the average length of stay is 62 days. The average cost per mental patient at the Dammasch Hospital is about $800, as against $2,000 to $3,000 per patient at the larger state hospitals in Oregon. Furthermore, and this is a most significant point, this small hospital admits as many patients as any of the larger hospitals with five and ten times its number of beds.

At the 125-bed Fort Logan Mental Health Center near Denver, Colorado, statistics for the first year of operation indicate roughly the same kind of experience as in Oregon.

The most dramatic break away from the custodial institution is taking place in Georgia. In 1960, the state opened four psychiatric units in general hospitals in its major cities. In about two years of operation, 1,800 patients from 151 counties in Georgia have been treated in these units, which really serve as community mental health centers. Although the daily cost to the state has been high -- $30 to $35 -- the approximate cost per patient has only been about $1,000, considerably less than the cost of long-term treatment in the 12,000-bed state hospital at Milledgeville.

Even more important than the economic savings have been the savings in human resources. After they were treated in the general hospitals, only 7% of the patients were sent on to Milledgeville. Furthermore, and this is the most remarkable statistic, one-fourth of the patients, who were not employed before hospitalization, were able to obtain jobs after being discharged from one of these psychiatric units.

In Illinois, the average stay in psychiatric units in general hospitals is sixteen days. Although the per diem cost of some of these units has run as high as $35 per

day, the total cost per patient has been approximately 50% of the cost per patient in the state mental hospitals. This favorable experience in Illinois led Governor Kerner to recommend, and the people to support by a bond issue, the construction of six 300-bed community mental health centers so located that the vast majority of its citizens will be but an hour's drive from a complete range of mental health services for both adults and children.

Massachusetts is currently operating a pilot community psychiatric center and is now considering the construction of six to eight additional mental health centers in various parts of the state.

Space does not permit a detailed discussion of additional community mental health centers either now in operation or being planned in Connecticut, Ohio, Arkansas, Missouri, Kentucky and California.

In staffing these new centers, the President points out that for the first time a large proportion of our private practitioners of medicine will have the opportunity to treat their patients in a mental health facility geographically accessible to their daily practice.

Will the medical profession cooperate in this endeavor?

The attitude of the American Medical Association is clear and affirmative on this point. In June, 1962, its Board of Trustees declared:

> "Mental illness is America's most pressing and complex health problem. . . The American Medical Association recognizes the important stake every physician, regardless of type of practice, has in improving our mental health knowledge and resources."

The American Medical Association also recognized the need for greatly expanded psychiatric manpower and greatly increased financing for all types of mental health services when it formally resolved in 1962 that:

> "Shortages in mental health personnel and facilities are related to a shortage of funds available for mental health needs. Few communities have the resources necessary for adequately developing and expanding their mental health services. For this reason, the AMA supports multiple source financing for community mental health services and recognizes the need for additional expenditures, at all levels, in this area."

In the long-term financing of these centers, heavy reliance is placed upon the role of voluntary health insurance in expanding coverage of psychiatric treatment. This is welcome recognition of the fact that proclaiming mental patients wards of the state and providing these "incurables" with bed and board is no longer sufficient. In relocating treatment of this illness from isolated institutions to the mainstream of medicine, we urge insurance plans operating in the private sector of our economy to recognize a heightened responsibility for coverage of a disease which is highly treatable and has an excellent prognosis for recovery.

There is every reason to believe that this proposal will receive the support necessary to make it a reality. One several occasions, the National Governors' Conference has gone on record proposing that mental illness be covered on an equal basis with physical illness. The American Medical Association has taken a similar position, noting that "voluntary, pre-paid health insurance programs should be expanded, on a basis analagous to ordinary physical and surgical care, to cover the costs of mental illness."

The President's proposals are ambitious and challenging. In broad outline, they envision an end to the nightmare of isolation and neglect which has cursed the mentally ill since the beginning of recorded history.

As a realizable goal, the President envisages a reduction of 50% of the number of patients how under custodial care in the next decade or two, if we launch a bold, new mental health program now.

I can assure you that the people are ready, the Governors are ready, the medical profession is ready -- all are eager to unite in this great crusade.

If you will give us the necessary tools, we will do the job.